

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/19/2013
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 1/8/13.</p> <p>Survey dates: April 17, 18 and 19, 2013</p> <p>Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 4/23/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 3 of 6 clients living at the group home (#2, #3 and #5), the facility failed to ensure the clients accessed their client funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 4/17/13 at 3:03 PM. The facility did not provide documentation indicating clients #2, #3 and #5 accessed their client funds. Clients #2 and #3 had not accessed their funds since 9/21/12. Client #5 had not accessed his funds since 9/21/12.</p> <p>The Supported Group Living Manager (SGLM) was interviewed on 4/17/13 at 3:03 PM. The SGLM indicated there was no documentation indicating clients #2, #3 and #5 accessed their client funds since the survey conducted on 1/8/13.</p> <p>This deficiency was cited on 1/8/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	W000126	<p>QIDP reviewed with staff again the expectation that each client have the opportunity to access their personal funds. The expectation is that at least monthly each client will be able to spend from his personal petty cash money. The QIDP or her assistant have verified that in April, each client had this opportunity. Each month, the QIDP or assistant will review each client's petty cash report to confirm that the client's are accessing their funds. Responsible for QA: QIDP</p>	05/19/2013			

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	9-3-2(a)			